



**Belknap-Merrimack  
Head Start/ Early Head Start**

**Office Use Only**

Center \_\_\_\_\_  
 Program Option \_\_\_\_\_  
 Program Year \_\_\_\_\_

**Prenatal Application for Enrollment**

Prenatal Parent: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address if different: \_\_\_\_\_

Phone #: \_\_\_\_\_ cell/home/work Email: \_\_\_\_\_

Hispanic:      Yes      No

Race:    Asian      American Indian/Alaska Native      Hawaiian/Pacific Islander      Black  
           White      Multi-Racial      Other: \_\_\_\_\_

**Education Level:**

- Less than high school graduate
- High school graduate/GED
- Some college, vocational, or associate degree
- Bachelor degree or advanced

**Employment Status:**

- Full time
- Part time
- Seasonal
- Unemployed
- Retired/disabled
- Job training/School

**Military:**

- Active Duty
- Former (Veteran)

**Pregnancy Information**

Estimated due date: \_\_\_\_\_

Have you received Prenatal care? \_\_\_\_\_

Name of OBGYN: \_\_\_\_\_

Do you have health insurance or Medicaid? \_\_\_\_\_

Date of next prenatal visit: \_\_\_\_\_

Have you experienced complications in this or previous pregnancies?      Explain:

Second Parent: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address if different: \_\_\_\_\_

Phone #: \_\_\_\_\_ cell/home/work Email: \_\_\_\_\_

Hispanic: Yes No

Race: Asian American Indian/Alaska Native Hawaiian/Pacific Islander Black  
White Multi-Racial Other: \_\_\_\_\_

**Education Level:**

- Less than high school graduate
- High school graduate/GED
- Some college, vocational, or associate degree
- Bachelor degree or advanced

**Employment Status:**

- Full time
- Part time
- Seasonal
- Unemployed
- Retired/disabled
- Job training/School

**Military:**

- Active Duty
- Former (Veteran)

**Additional Household Members**

Name	DOB	Gender	Relationship

**Demographic Information**

Primary language spoken in home: \_\_\_\_\_. Are you learning a language in addition to English? \_\_\_\_\_. Do you require an interpreter? \_\_\_\_\_

**Homeless: Yes No** If homeless please select which best describes your primary nighttime residence:  
Temporarily sharing the housing of others (family, friends, etc) due to loss of housing, economic hardship, or similar reason. Emergency or transitional shelter/ housing Hotel/motel  
Campground Other: \_\_\_\_\_

**Referred by DCYF?** Yes No **Receiving Food stamps?:** Yes No **On WIC?** Yes No

**Family Circumstances** *Check all that apply:*

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>
Mental Health Services			Incarcerated Parent			2 or more children under age 3		
Disabled family member			Current teen parent			Single parent		
History of substance abuse			Non-High school graduate			Does child have a doctor		
History of Domestic Violence			New American/ Refugee family			Does child have a dentist		
DCYF involvement			Non-English speaking			Current/ past military (parent/guardian)		

**Family Income**

Family income must be verified by the Head Start/ Early Head Start program before determining that a child/ prenatal parent is eligible to participate in the program. Income must include income from ALL sources for the past 12 months or the previous calendar year (whichever more accurately reflects your current situation). This includes, but is not limited to, child support for other children in the home, cash assistance, employment, Social Security, and TANF.

**Applications cannot be processed until all income verification has been received. Please include these with your application.**

<b>Income by family member</b>	<b>Gross amount (before taxes)</b>	<b>Time period (monthly, weekly, bi-weekly, etc)</b>	<b>Source of income (employer, TANF, child support, etc)</b>

**For office use only: Total Yearly Income: \$**\_\_\_\_\_

**Certification:** I hereby certify that the information I have provided on this application is complete to the best of my knowledge and provides a true summary of my income and needs. I understand that I am required to provide documentation or other verification of the sources of my income.

\_\_\_\_\_  
*Parent/ guardian signature*

\_\_\_\_\_  
*Date*

**Assurance of Confidentiality:** The information you provide will help us deliver or direct services most appropriate for your family's needs. All information will be held in strict confidence.

**Return to:** The center nearest to you OR email to [Headstart@capbm.org](mailto:Headstart@capbm.org)

**OR mail to: Community Action Program Belknap/Merrimack County, Inc**  
**PO Box 1016**  
**Concord NH 03302-3295**

**OR fax to: 603-228-1898**

**Program Staff Interview:**

**In person**

**On telephone due to:** \_\_\_\_\_

**Staff printed name:** \_\_\_\_\_

**Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

**Enrollment Staff Certification:** I hereby certify that I have seen and reviewed the income documentation or other forms of verification identified in this application. No information has been intentionally altered or omitted. I understand that actions may be taken which may affect my employment at Belknap-Merrimack Head Start/ Early Head Start for intentionally submitting false information.

\_\_\_\_\_  
*Enrollment staff signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Enrollment staff printed name*

\_\_\_\_\_  
*Second look staff signature*

\_\_\_\_\_  
*Date*

Income eligible

Foster child

Public Assistance

Homeless

Over income

Date waitlisted: \_\_\_\_\_ Letter sent: \_\_\_\_\_ Date accepted: \_\_\_\_\_